

Item 20 Film 391 7-31 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

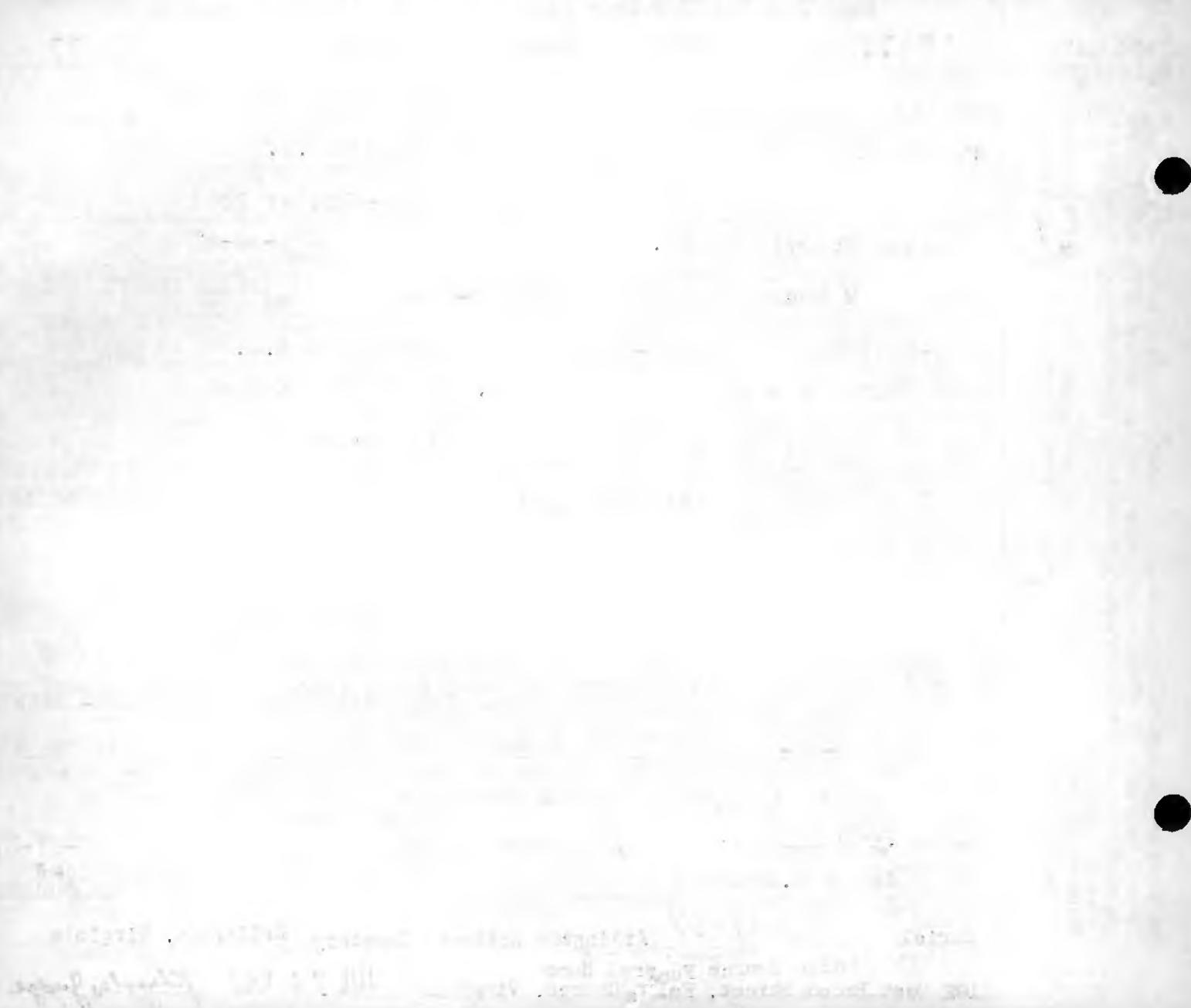
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and 2 with the State Department of Health or my designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

09477

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09477

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stump Neck</b>		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>3926-Wheeler Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH <b>7-16-67</b>	
3. NAME OF DECEASED <b>John Henry Bean Jr.</b>		First	Middle
4. DATE OF DEATH <b>7-16-67</b>	Month	Doy	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-13-34</b>
9. AGE (In years lost birthday) yrs. <b>33</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. DAYS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Navy-Enlisted</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US-Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Henry Bean Sr</b>		14. MOTHER'S MAIDEN NAME <b>Sadie Agnes Stubbs</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>570746-8577</b>	
17. INFORMANT <b>Navy Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fatal Submersion</b>  929.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>On a picnic at Stump Neck. Was swimming in a pond when he suddenly sank. Body recovered about 30 min. later.</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>7 p.m. 7-16- 19 67</b>		20d. INJURY OCCURRED While Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Recreation Center</b>	
20f. (City or town) <b>Charles Md.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>James E. Andrews</i>		EXAMINER'S NAME (Type) <b>James E. Andrews</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-21-67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <i>Falls Church Funeral Home</i> 1102 West Broad Street, Falls Church, Virginia		25a. RECD BY REGISTRAR DATE JUL 24 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09478

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09478		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
1. PLACE OF DEATH a. COUNTY <b>Charles</b>		b. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians General Hospital</b>		e. STREET ADDRESS <b>Nanjemoy</b>	
3. NAME OF DECEASED (Type or print) <b>Smith</b>		First <b>Emory</b>	Middle <b>Bowie</b>
4. DATE OF DEATH <b>July 13 1967</b>	Month <b>July</b>	Day <b>13</b>	Year <b>1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>May 5, 1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Charles County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph E. Bowie</b>		14. MOTHER'S MAIDEN NAME <b>Edith M. Maddox</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-24-899</b>	
17. INFORMANT <b>Harry B. Bowie, Nanjemoy, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive left hemothorax</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Perforation of left lung and aorta</b> (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARILY OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>Subject shot in chest</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:15 p.m. 7 13 1967</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>His store</b>
20f. (City or town) <b>Nanjemoy</b>		(County) <b>Charles</b>	
(State) <b>Md.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Russell S. Fisher</i>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 17, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Nanjemoy, Baptist</b>		23d. LOCATION (City or Town) (County) (State) <b>Nanjemoy, Charles, Md.</b>	
24. FUNERAL DIRECTOR <b>Arehart Funeral Home Inc., La Plata, Md.</b>		ADDRESS	
		25a. REC'D BY REGISTRAR <b>JUL 21 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>John Clark's signature</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09479

09479

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hughesville</b>		c. LENGTH OF STAY IN 1b <b>3 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <b>Hughesville,</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Oscar Penn Bridgett</b>		First <b>Oscar</b>	Middle <b>Penn</b>
4. DATE OF DEATH <b>July 17, 1967</b>	Month <b>July</b>	Day <b>17</b>	Year <b>1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>May 21, 1875</b>		9. AGE (In years last birthday) <b>92 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Charles Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Thomas Bridgett</b>		14. MOTHER'S MAIDEN NAME <b>Lucrecia Dent</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-36-5776</b>	
17. INFORMANT <b>Adrian Bridgett, Hughesville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c) <b>Attherosclerotic C.V. disease</b>		15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>July 13 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Mechanicsville</b>
20f. (City or town) <b>Mechanicsville</b>		(County) <b>Maryland</b>	(State) <b>Md.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>66</b> , to <b>July 17</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>July 13 1967</b> , and that death occurred at <b>M</b> from causes and on the date stated above.		22b. DATE SIGNED <b>7-18-67</b>	
22a. SIGNATURE <b>J. Roy Guyther</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>J. Roy Guyther M.D.</b>		22d. ADDRESS <b>Mechanicsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-20-67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Trinity Ch. Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Newport, Charles, Md.</b>	
24. FUNERAL DIRECTOR <b>Huntt Funeral Home, Waldorf, Md.</b>		25a. ADDRESS <b>ADDRESS</b>	
		25b. REC'D BY REGISTRAR <b>JUL 21 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

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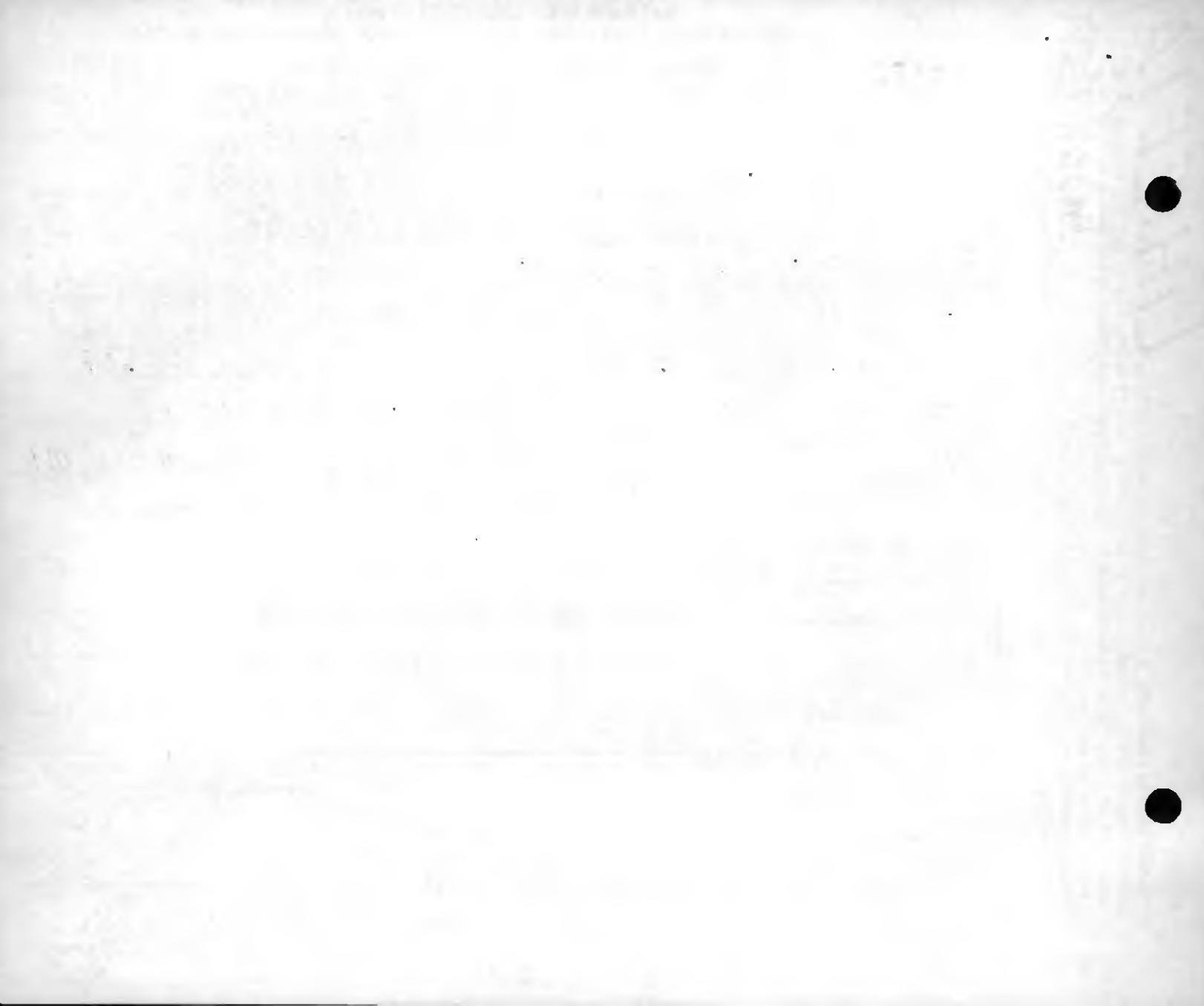
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09480 09480

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>INDIAN Head</b>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>INDIAN Head</b>	b. COUNTY <b>CHARLES</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS <b>154 CIRCLE AVE</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SALLIE H. BYRD</b>	First <b>S</b>	Middle <b>A</b>	Last <b>BYRD</b>
4. DATE OF DEATH Month <b>7</b>	Month <b>7</b>	Day <b>26</b>	Year <b>67</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 15 1888</b>
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>79 yrs</b>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>OCM</b>	11. BIRTHPLACE (State or foreign country) <b>VA.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>SAM WALL</b>	14. MOTHER'S MAIDEN NAME <b>NANNIE DUNNINGTON</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>W</b>	
16. SOCIAL SECURITY NO. <b>4201</b>	17. INFORMANT <b>Charles H. Byrd</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. INTERVAL BETWEEN ONSET AND DEATH <b>Chorovary Occlusion</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E.J. Edelen</b>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED <b>7-2-67</b>
EXAMINER'S NAME (Type) <b>E.J. Edelen, LA PLATA MD</b>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7-5-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>TRINITY Memorial</b>	23d. LOCATION (City or Town) (County) (State) <b>Waldorf, MD</b>
24. FUNERAL DIRECTOR <b>South Funeral Home</b>	ADDRESS <b>Waldorf, MD</b>	25a. REC'D BY REGISTRAR DATE <b>JUL 6 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Juge</b>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

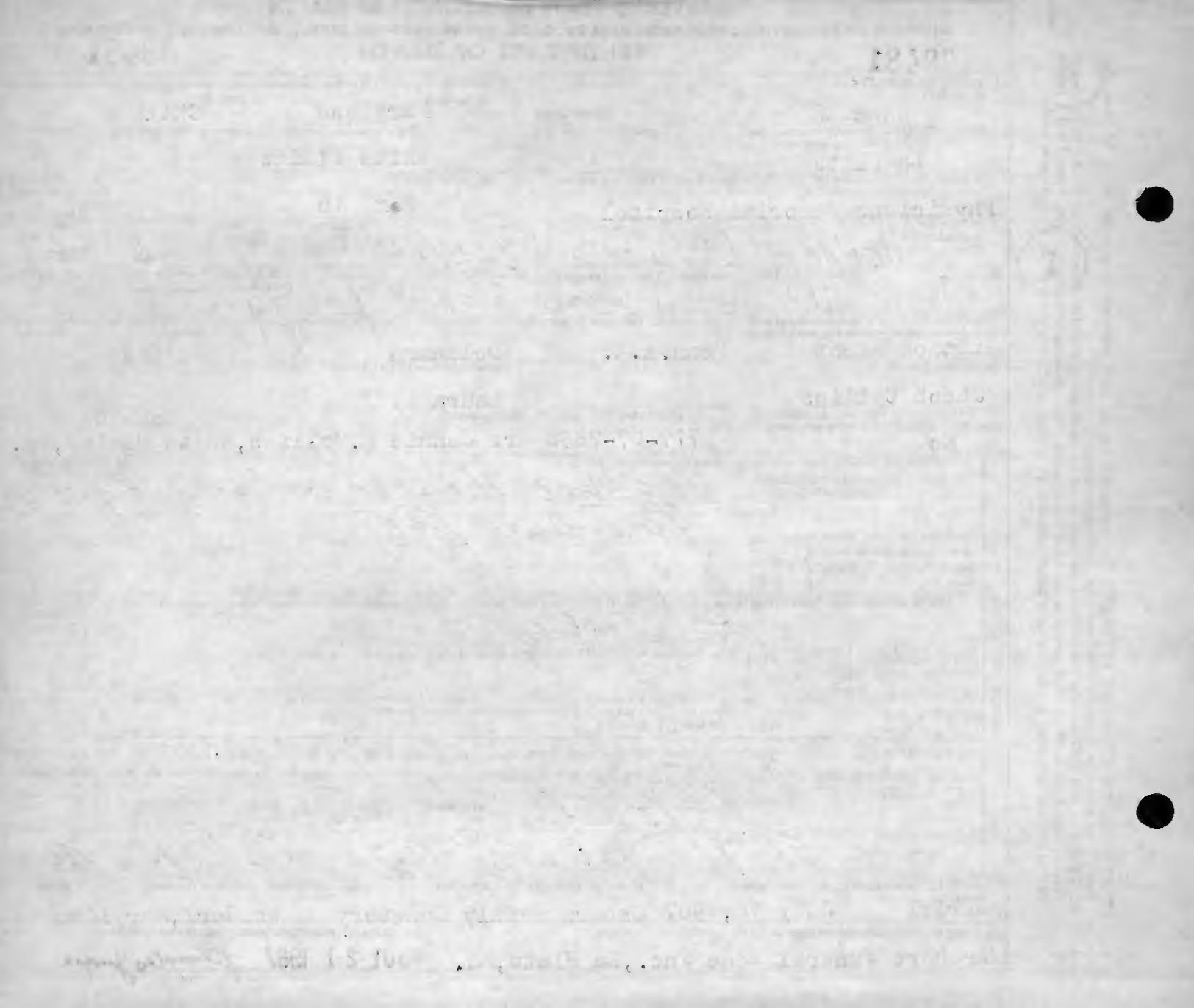
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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

09481 09481

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>CHARLES</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>				
3. NAME OF DECEASED (Type or print) <b>HORACE LIVWOOD COLLINS</b>		First      Middle      Last	4. DATE OF DEATH Month <b>7</b> Day <b>15</b> Year <b>1967</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <b>8-8-87</b>	9. AGE (In years last birthday) <b>79 yrs.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Station Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penn. R.R.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Delaware</b>			
13. FATHER'S NAME <b>Jacob Collins</b>		14. MOTHER'S MAIDEN NAME <b>Laura ?</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>717-07-7858</b>	17. INFORMANT Address <b>Box 16 Mrs Jennie M. Collins, White Plains, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <b>7-12-67</b>				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b>		DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>				
		(b)				
		DUE TO <b>Debile</b>				
		(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes m-</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>7-12-67</b>				
20c. TIME OF INJURY Hour e.m. p.m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>White Plains, N.Y.</b>	20f. (City or town) <b>White Plains</b>	(County) <b>Westchester Co.</b>	(State) <b>N.Y.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>7-12-67</b> to <b>7-15-67</b> , that (I) (we) last saw the deceased alive on <b>7-15-67</b> , and that death occurred at <b>White Plains, N.Y.</b> M, from the causes and on the date stated above.				22b. DATE SIGNED <b>7-15-67</b>		
22c. SIGNATURE <b>F. J. Edelstein</b>		ATTENDING PHYS. <b>F. J. Edelstein</b>	MED. DIRECTOR <b>MD. La Plata</b>	STAFF PHYS. <b>La Plata</b>	22d. ADDRESS <b>Edelstein M.D. La Plata N.Y.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 18, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Osborn Family Cemetery</b>	23d. LOCATION (City, town or county) <b>Waldorf, Maryland</b>	(State) <b>Maryland</b>		
24 FUNERAL DIRECTOR'S SIGNATURE <b>Arehart Funeral Home Inc., La Plata, Md.</b>	ADDRESS <b>Arehart Funeral Home Inc., La Plata, Md.</b>	25a. REC'D BY REGISTRAR <b>Charles J. Arehart</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. Arehart</b>	DATE <b>JUL 21 1967</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, remove carbon papers. Page 1 and 2 director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09482

CERTIFICATE OF DEATH

09482

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Charles Maryland		Maryland Charles	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1D	
Bryans Road			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
		13 Gabriele Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
Loretta Michelle Comeau		July 24 1967	
5. SEX		6. COLOR OR RACE	
F		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Cau.		8. DATE OF BIRTH	
		Jan. 11, 1961	
9. AGE (In years) IF UNOER 1 YEAR IF UNOER 24 HRS. last birthday Months Days Hours Min.		6 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (County & State, or foreign country)	
		Maryland	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Louis Edward Comeau		Laura Vanwart	
15. WAS DECEASED EVER IN U.S. ARMEED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes give war or dates of service)		17. INFORMANT	
-		Louis E. Comeau	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		Days	
DUE TO (b)		Cardiac Failure	
DUE TO (c)		Neuroblastoma	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1940.	
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/28, 1962, to 7/24, 1967, that (I) (we) last saw the deceased alive on 7/23 1967, and that death occurred at 10 AM, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE		Thomas L. Fieldson	
22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
Thomas L. Fieldson MD.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		23c. NAME OF CEMETERY OR CREMATORIUM	
7-27-67		Mt. Olivet	
24. FUNERAL DIRECTOR		23d. LOCATION (City, town or county) (State)	
The Hunt Funeral Home, Wallorf, Md.		Washington D.C.	
ADDRESS		25a. REC'D BY REGISTRAR	
		JUL 31 1967	
25b. REGISTRAR'S SIGNATURE		Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09483

## CERTIFICATE OF DEATH

09483

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Charles</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c LENGTH OF STAY IN lb <b>18 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>		e. STREET ADDRESS <b>Issue</b>	
3. NAME OF DECEASED (Type or print) <b>MARY</b>		First <b>G.</b>	Middle <b>DONLEY</b>
4. DATE OF DEATH <b>July 28 1967</b>	Month <b>July</b>	Day <b>28</b>	Year <b>1967</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>3-26-90</b>
9. AGE (in years by birthday) <b>77 yrs</b>	10. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JAMES BURRGOUHS</b>		14. MOTHER'S MAIDEN NAME <b>JULLA SWANN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <b>NO</b>		16. SOCIAL SECURITY NO <b>218-30-4978A</b>	17. INFORMANT <b>Mrs. Ethel Butler-Daughter-Issue, Inc.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>Diabetes Mellitus</b> <b>10 years</b> <b>Carcinoma of the Sigmoid</b> <b>6 months</b>	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>La Plata</b>		(County) <b>Maryland</b>	
(State) <b>MD</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>7-20 1967</b> to <b>7-28 1967</b> , that (I) (we) last saw the deceased alive on <b>7-28 1967</b> , and that death occurred at <b>La Plata, Md.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>M. Johnson</b>		22b. DATE SIGNED <b>7-28-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>F.M. Johnson MD</b>		22d. ADDRESS <b>La Plata, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/31/1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Ghost Cemetery</b>
23d. LOCATION (City or Town) <b>La Plata</b>		(County) <b>Maryland</b>	
(State) <b>MD</b>			
24. FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc.-La Plata, Md.</b>		ADDRESS	
25a. REC'D BY REGISTRAR <b>Charles Jungen</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jungen</b>	
DATE <b>AUG 1 1967</b>			



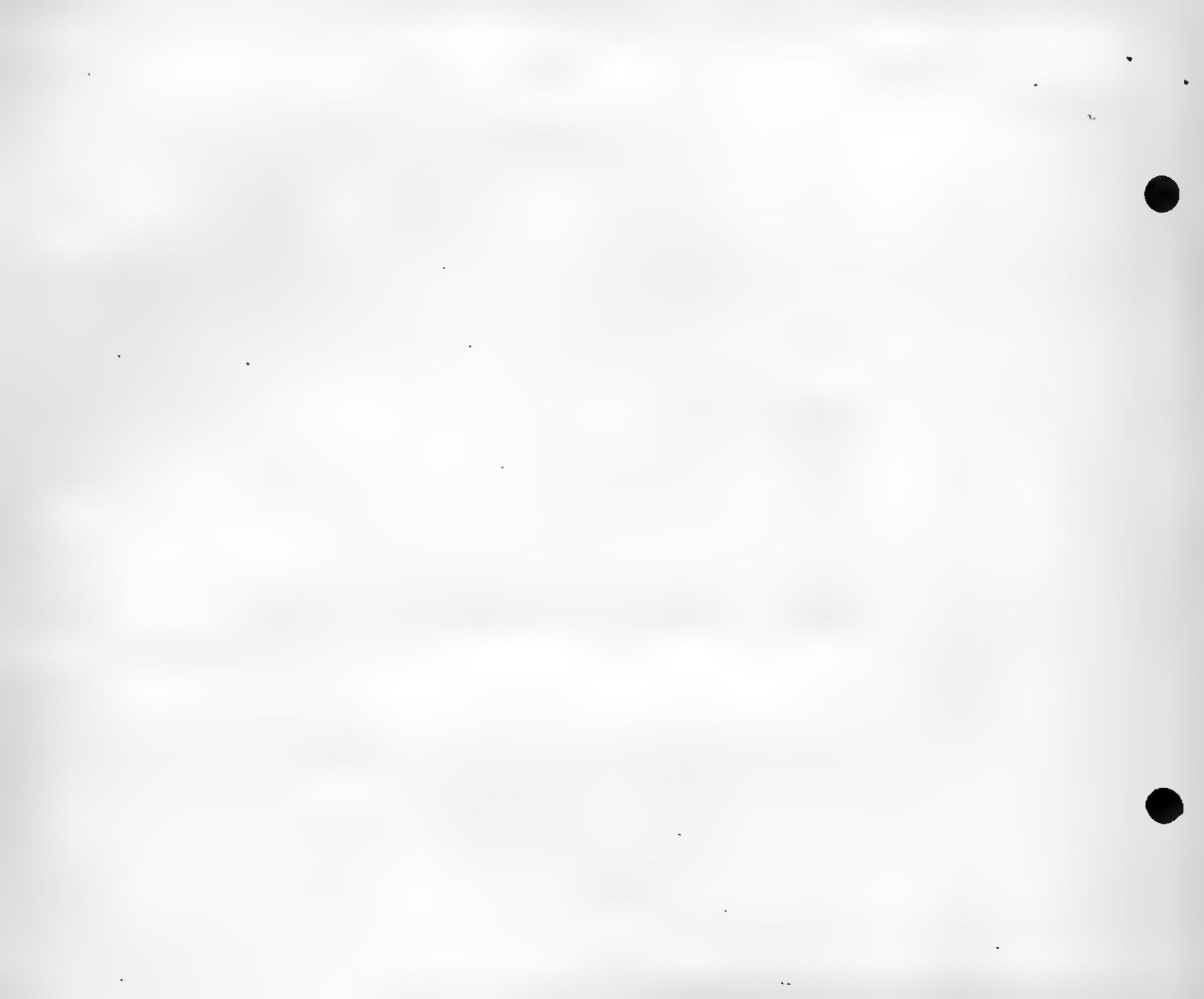
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1 PLACE OF DEATH a. COUNTY <b>Charles</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b>		c. LENGTH OF STAY IN 1b 11 hours	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bryantown</b>		d. STREET ADDRESS <b>Edelen Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospt.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Edward</b> First <b>Q.</b> Middle <b>L.</b>		4 DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1967</b>	
5 SEX <b>M</b> 6 COLOR OR RACE <b>Cau.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. U.S. JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Bryantown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin M. Edelen</b>		14. MOTHER'S MAIDEN NAME <b>Mary T. Gardner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>577-16-2288</b>	
17. INFORMANT <b>Edelen B. Edelen</b>		Address <b>Bryantown Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4500 Congestive heart failure</b>			
DUE TO (b) <b>Subacute appendicitis</b>			
DUE TO (c) <b></b>			
7 days.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertension</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Bryantown</b> (County) <b>Charles</b> (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>7/21/67</b> to <b>7/22/67</b> , that (I) (we) last saw the deceased alive on <b>7/28/67</b> , and that death occurred at <b>8034 M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>7/29/67</b>	
22a. SIGNATURE <b>Arthur M. Monteiro</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Arthur M. Monteiro</b>		22d. ADDRESS <b>1000 Charles St. Baltimore Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 31, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>St. Marys Cemetery, Wallingford, Md.</b>		23d. LOCATION (City or Town) <b>Bryantown, Chas. Md.</b> (County) <b>Charles</b> (State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>The Hunt Funeral Home, Wallingford, Md.</b>		25a. REC'D BY REGISTRAR <b>Aug 1 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>James J. Moore</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or by the hospital or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

29485		29485	
1. PLACE OF DEATH a. COUNTY <b>CHARLES</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b <b>NANJEMOY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physician Memorial Hospital</b>		e. STREET ADDRESS	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JAN</b>		First	Middle
		<b>S.</b>	<b>HANCOCK</b>
4. DATE OF DEATH Month <b>JULY</b>		Day <b>13</b>	Year <b>1967</b>
S. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
		DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 14, 1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Charles County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Hancock</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Bradshaw</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address <b>Gerald Hancock-son- Nanjemoy, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), <b>X</b>		DUE TO (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>La Plata</b>		(County) <b>Md.</b> (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-13</b> , 1967 to <b>7-13</b> , 1967, that (I) (we) last saw the deceased alive on <b>7-13-1967</b> , and that death occurred at <b>La Plata, Md.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>F. M. Johnson</b>		ATTENDING M.D. <input type="checkbox"/> PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>F. M. Johnson</b>		22d. ADDRESS <b>LA PLATA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 16, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Nanjemoy Baptist</b>
24. FUNERAL DIRECTOR <b>Arehart Funeral Home Inc., La Plata, Md.</b>		ADDRESS	25a. LOCATION (City or Town) <b>Nanjemoy, Charles, Md.</b>
			(County) <b>Md.</b> (State)
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
		RECD BY REGISTRAR <b>JUL 21 1967</b>	DATE



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

**10. HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**11. FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Yorkton Papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Charles</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If out'side corporate limits, write RURAL and give nearest town) <b>La Plata</b>			c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>			d. STREET ADDRESS <b>P. O. Box 264</b>		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>First Baby Girl Hill</b>			4. DATE OF DEATH <b>July 24, 1967</b>	Month <b>July</b>	Doy Year <b>24 19</b>
S. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>7/24/67</b>	9. AGE (In years lost birthday) yrs <b>3 47</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sofair</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Charles Washington</b>		14. MOTHER'S MAIDEN NAME <b>Dorrie Octavia Hill</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mother</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> 7615 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Placenta Praevia Anterior</b> DUE TO (c) <b>4 Dips.</b> INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>7/24 1967</b>		20f. (City or town) (County) (State) <b>7/24 1967</b>
21. I certify that (I) (this hospital) attended the deceased from <b>7/24 1967</b> to <b>7/24 1967</b> , that (I) (we) last saw the deceased alive on <b>7/24 1967</b> , and that death occurred at <b>7/24 1967</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>Arturo M. Montiero MD</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>7/24 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arturo M. Montiero MD</b>		22d. ADDRESS <b>La Plata, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Society) <b>St Peters</b>		23b. DATE THEREOF <b>7-26-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>St Peters</b>	23d. LOCATION (City or Town) (County) (State) <b>Waldorf clos</b>	
24. FUNERAL DIRECTOR <b>Richard Inc La Plata Md</b>		ADDRESS		25a. RECD BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
DATE <b>JUL 31 1967</b>					



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" on pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE	
<i>Charles</i> MARYLAND		b. COUNTY <i>Clay -</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give road address) <i>Holiday Inn</i>		c LENGTH OF STAY IN 1b <i>5 mos.</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>214 Cicada Rd.</i>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>CHARLES EDWARD HUBBERT</i>		4. DATE OF DEATH Month <i>'67</i> Day <i>13</i> Year <i>1967</i>	
S SEX <i>M</i>	6 COLOR OR RACE <i>U.</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>7-6-15</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>ADJUSTER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>INSURANCE</i>	
11 BIRTHPLACE (State, foreign country) <i>MARYLAND</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13 FATHER'S NAME <i>ALVIN C. HUBBERT</i>		14 MOTHER'S MAIDEN NAME <i>MARY BURGRAF</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>YES WWII</i>		16 SOCIAL SECURITY NO <i>Unknown</i>	
17 INFORMANT <i>MRS. JEANNE C. HUBBERT, SEE #2</i>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Confusion</i> DUE TO <i>Alcohol</i> <i>Off race</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1-1-7-86</i>	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <i>Alcohol</i> DUE TO (c) <i>Alcohol</i> <i>Alcohol abuse</i>			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour am pm <i>19</i>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, office bldg., etc.) <i>House</i>		20f (City or town) <i>Salisbury</i> (County) <i>Clay Co.</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. J. E. DELIER</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. E. DELIER</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town or county) <i>100 N. Main St., P.O. Box 100, Clay, MD 21622</i>	
22. DATE SIGNED <i>7-18-67</i>			
23a BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>		23b DATE THEREOF <i>7/16/1967</i>	
23c NAME OF CEMETERY OR CREMATORIUM <i>PARSONS CEMETERY</i>		23d LOCATION (City or Town) <i>SALISBURY</i> (County) <i>W. CO. MD.</i>	
24 FUNERAL DIRECTOR ADDRESS <i>The Hunt Funeral Home, Walkersville, Md.</i>		25a RECD BY REGISTRAR DATE <i>JUL 18 1967</i>	
		25b REGISTRAR'S SIGNATURE <i>Charles J. George</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

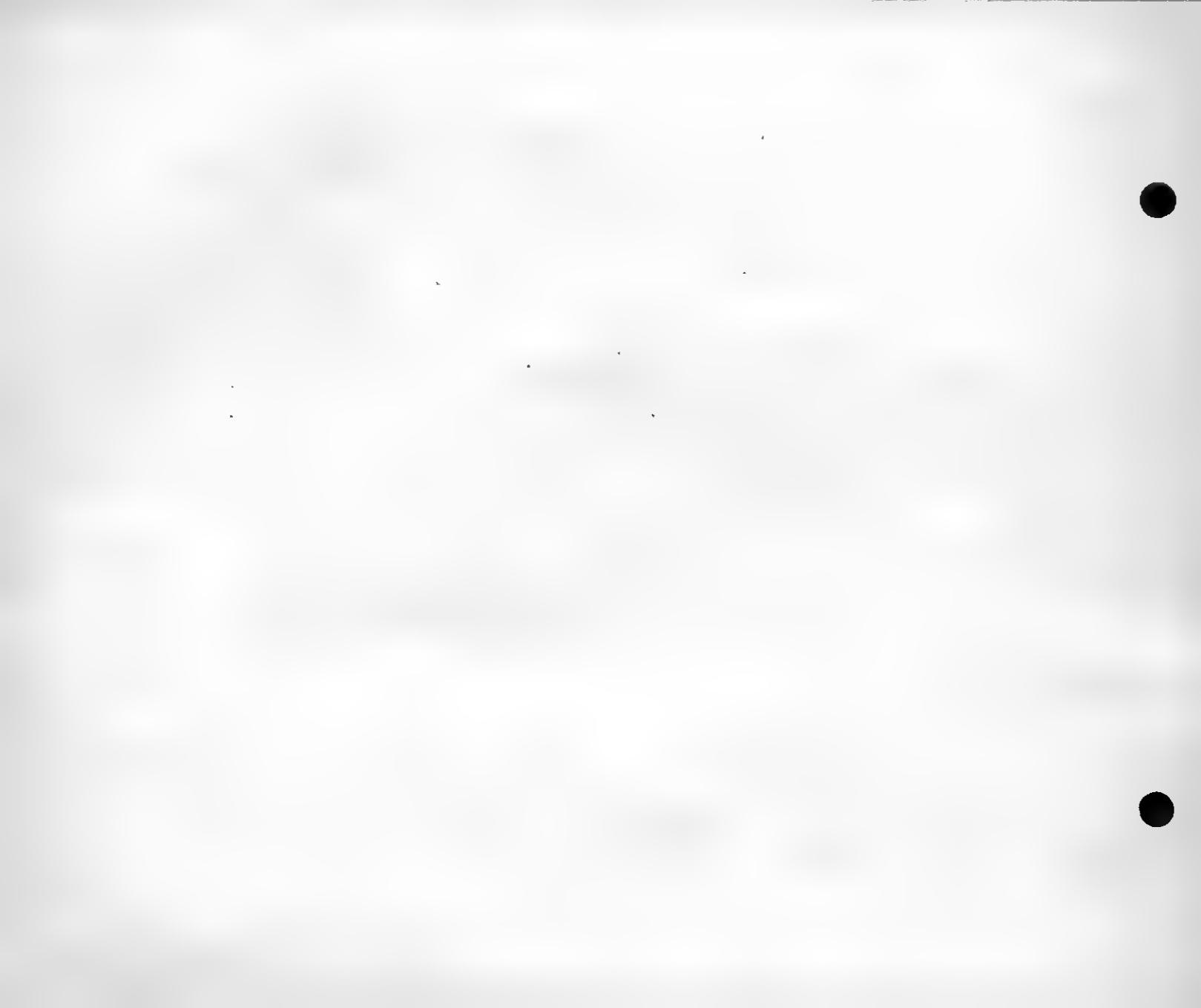
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3 form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <i>Charles</i>		2 USUAL RESIDENCE (Where deceased lived or institution Residence before admission) a STATE <i>Virginia</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>King George</i>		c LENGTH OF STAY IN 1b <i>King George</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Doyley West Hosp</i>		d STREET ADDRESS <i>King George</i>	
3 NAME OF DECEASED (Type or print) <i>JAMES D Hudson</i>		First <i>D</i>	Middle <i>Hudson</i>
4 DATE OF DEATH <i>7-16-67</i>		5 DATE <i>7-14-36</i>	6 MONTH <i>July</i>
7 DAY <i>16</i>		8 YEAR <i>1967</i>	
9 SEX <i>M</i>		10 COLOR OR RACE <i>W</i>	11 DATE OF BIRTH <i>7-14-36</i>
12 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		13 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	14 AGE (In years (last birthday) yrs) <i>31</i>
15 USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Installer</i>		16 KIND OF BUSINESS OR INDUSTRY <i>C&amp;P Telephone Service</i>	
17 BIRTHPLACE (State or foreign country) <i>Virginia</i>		18 CITIZEN OF WHAT COUNTRY <i>USA</i>	
19 PARENT'S NAME <i>James D Hudson</i>		20 MOTHER'S MAIDEN NAME <i>Mary Morris</i>	
21 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		22 INFORMANT <i>Father King George</i>	
23 SOC A SEC JUR TY NO <i>03039-44-376</i>		24 ADDRESS <i>King George</i>	
25 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>8234</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>bleeding from</i>		26 INTERVAL BETWEEN ONSET AND DEATH <i>1-6-67</i>	
27 DUE TO <i>bleeding from</i>		28 DUE TO <i>gas fuel and</i>	
29 DUE TO <i>Crashed car</i>			
30 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
31 PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		32 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury part I or Part II of page 18) <i>Driver of auto vehicle hit at tree</i>	
33 TIME OF INJURY Month Day Year Mo. 6m 16 1967		34 N. INJRY OCCURRED Whl <input type="checkbox"/> Not Wh <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	35 PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>King George</i>
36 DEATH RESULTED FROM Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		37 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
38 ACTUAL SIGNATURE <i>J. D. Hudson</i>		39 DATE SIGNED <i>7-16-67</i>	
40 EXAMINER'S NAME (Type) <i>J. D. Hudson</i>		41 ADDRESS (Street, city, town, or county) <i>King George</i>	
42 URAL CREMATION REMOVAL (Specify) <i>None</i>		43 DATE THEREOF <i>7-16-67</i>	
44 CEMETERY OR CREMATORIAL ADDRESS <i>Hawkins Church</i>		45 LOCATION (City or Town) <i>King George</i>	
46 FUNERAL DIRECTOR <i>Charles Judge</i>		47 RECD BY REGISTRAR <i>Charles Judge</i>	
48 ADDRESS <i>Charles Judge</i>		49 REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09488

## CERTIFICATE OF DEATH

09489

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b>	
a. COUNTY <b>CHARLES</b> MARYLAND		a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WALDORF</b>	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS <b>215 GARNER AVE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physicians Mem. Hosp</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <b>CHARLES</b> Middle <b>J.</b> Last <b>MORRELL</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>2</b> Year <b>1967</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DIVORCED <input type="checkbox"/>	
WIDOWED <input type="checkbox"/>		B. DATE OF BIRTH <b>NOV. 4 1893</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Post Office Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov</b>	
11. BIRTHPLACE (County & State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13. FATHER'S NAME <b>CHARLES MORRELL</b>		14. MOTHER'S MAIDEN NAME <b>ANN Zimmerman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>yes</b> (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>077-30-2038</b>	
		17. INFORMANT <b>Ruth G. Morrell</b>	
		Address <b>215 GARNER AVE WALDORF, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Emphysema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>527.1</b> (b) <b>COPULMONALE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>p.m.</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>WALDORF</b> (County) <b>MARYLAND</b> (State) <b>MD</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>6-24</b> , 1967, to <b>7-2</b> , 1967, that (I) (we) last saw the deceased alive on <b>7-1</b> , 1967, and that death occurred at <b>WALDORF</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>F. M. Johnson</b>		22b. DATE SIGNED <b>7-2-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. M. Johnson</b>		22d. ADDRESS <b>LA PLATA, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JULY 5 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>LONG ISLAND NAT CEM</b>		23d. LOCATION (City or Town) <b>New York</b> (County) <b>N.Y.</b> (State)	
24. FUNERAL DIRECTOR <b>Hunt Funeral Home</b>		25a. ADDRESS <b>WALDORF</b>	
		25b. REC'D BY REGISTRAR <b>Charles Judge</b>	
		DATE <b>JUL 5 1967</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 2 hours after death.

09480

08480

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH <b>Charles County</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland Charles</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fenwick Md</b>	c LENGTH OF STAY IN IB <b>36-Yrs</b>	b STATE <b>Maryland</b>	b COUNTY <b>Charles</b>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fenwick Md</b>	
		d STREET ADDRESS	
		e 5 RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Robert Morton</b>		First <b>John</b>	Middle <b>Robert</b>
4. DATE OF DEATH <b>7-25-67</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>2025-1889</b>
9. AGE (In years last birthday) <b>78</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
13. US OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired USGOVT.</b>	14. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Brooke Virginia</b>	
15. FATHER'S NAME <b>Joseph Morton</b>	16. MOTHER'S MAIDEN NAME <b>Hannah Campbell</b>	17. INFORMANT <b>Eliza Morton-Wife-Fenwick Md</b>	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	19. SOCIAL SECURITY NO <b>76-425-859</b>	20. ADDRESS	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion-Massive</b> DUE TO <b>Arterio-Sclerosis-General</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost			
INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
22. (b) DUE TO <b>Aging process</b> Indefinite			
23. (c) DUE TO Indefinite			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Emphysema</b>			
24. MEDICAL CERTIFICATION EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		25. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
26. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
28. (a) DATE OF AUTOPSY 7-25-67		(b) (c) (d)	
29. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
30. ACTUAL SIGNATURE <i>James E. Andrews MD</i>			
EXAMINER'S NAME (Type) <b>James E. Andrews MD</b>			
31. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		32. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
33. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		34. DATE SIGNED <b>7-25-67</b>	
35. Address (Street, city, town, or county) <b>Indian Head Md.</b>			
36. BURIAL/CREMATION, REMOVAL (Specify) <b>BURIAL</b>		37. DATE THEREOF <b>7-28-67</b>	
38. NAME OF CEMETERY OR CREMATORIAL <b>MAEODONIA BAPT. CHURCH</b>		39. LOCATION (City or Town) <b>BRYANS ROAD MD.</b>	
40. ADDRESS <b>WASHINGTON, D.C.</b>		(County) (State)	
41. FUNERAL DIRECTOR <b>BARNES &amp; MATTHEWS, INC. 3619-14 ST. N.W.</b>		42. REC'D BY REGISTRAR <b>JUL 28 1967</b>	
		43. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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09491

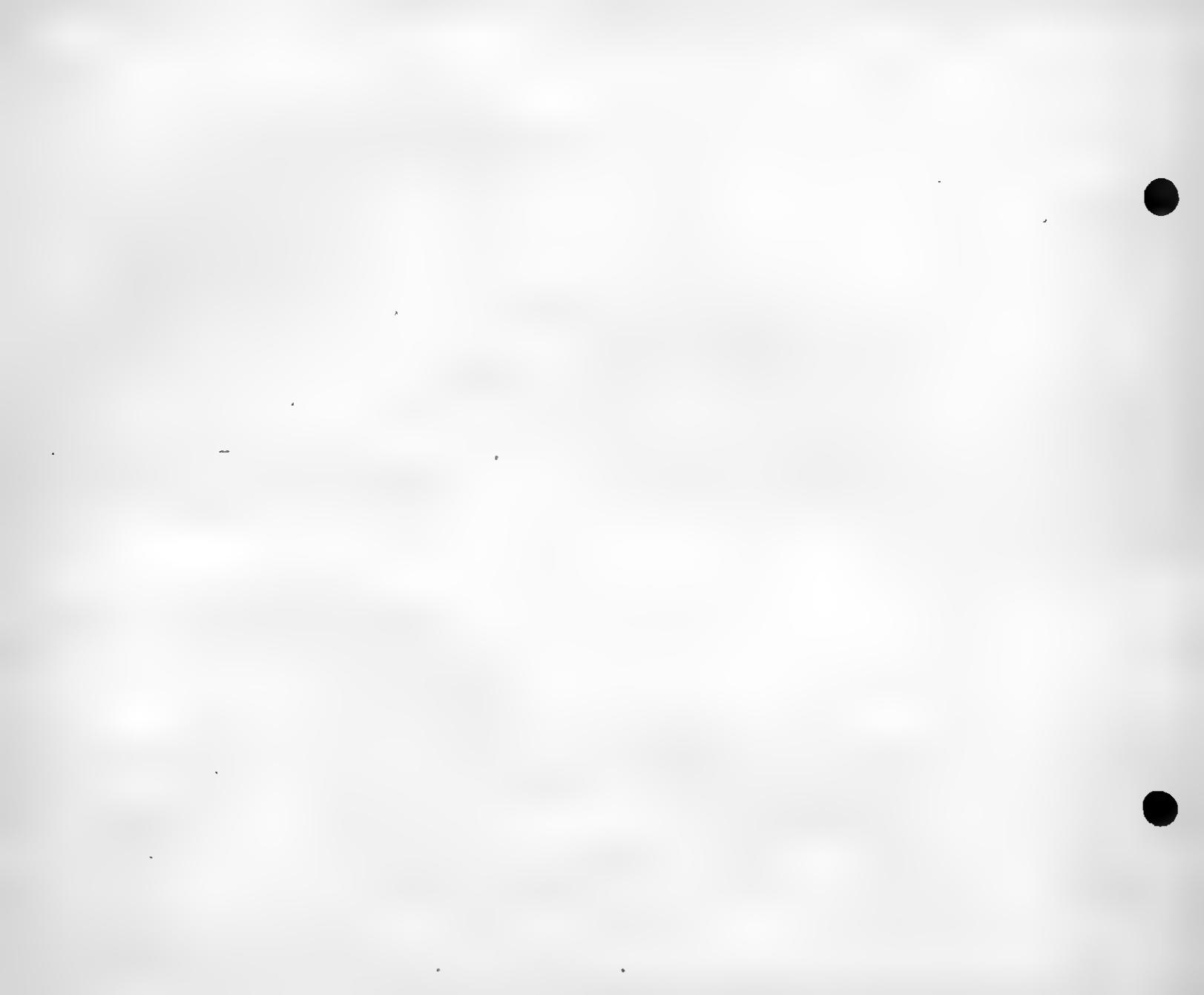
## CERTIFICATE OF DEATH

09491

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY  Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		d. STREET ADDRESS	
e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ETHEL	Middle CLARA	Last PENN
4. DATE OF DEATH JULY 27 1967	Month Day Year		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1918
9. AGE (In years at birthday) 49 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USAL OCCUPATION (Give kind of work done during most working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harold Beyer		14. MOTHER'S MAIDEN NAME Ethel (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mr. William Earl Penn-Cobb Island, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>WATERHOUSE-FRIEDRICHSEN SYNDROME</u> INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
DUE TO (b) <u>Renal infection</u> 3 days.			
DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-25-1967</u> , to <u>7-27-1967</u> , that (I) (we) last saw the deceased alive on <u>7-29-1967</u> , and that death occurred at <u>3A M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>F.M. Johnson MD</u>		22b. DATE SIGNED 7-27-67	
22c. PHYSICIAN'S NAME (Type) F.M. Johnson MD		22d. ADDRESS La Plata, Md, 20646	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/29/1967	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery
23d. LOCATION (City or Town) Suitland		(County) (State) Maryland	
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.		ADDRESS La Plata, Md.	25a. REC'D BY REGISTRAR DATE AUG 1 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.  
*M.D.*

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

29492

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

63492

1 PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2 USUAL RESIDENCE (Where deceased resided if institution residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>La Plata</i>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Waldorf</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Physicians Memorial Hospital</i>		d. STREET ADDRESS <i>Davis Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>ARTHUR</i>	First <i>A</i>	Middle <i>R</i>	Last <i>Proctor</i>
4. SEX <i>M</i>	5. COLOR OR RACE <i>C</i>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>March 5, 1916</i>
8. AGE (In years at last birthday) yrs <i>51</i>	9. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	10. IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	11. DATE OF DEATH <i>7th 11 67</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Heavy Equipment Operator-Gough</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cons., Waldorf, Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Andrew Proctor</i>		14. MOTHER'S MAIDEN NAME <i>Mary L. Thompson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>577-34-9281</i>	
17. INFORMANT <i>Mary Estelle Proctor-Wife-Waldorf, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for Part I, (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4.0.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>7/7/67</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Caraway Declension</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name farm, factory, street, office bldg., etc.) <i>Pomfret, Md.</i>
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E.J. Edelen</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <i>La Plata, Md.</i>	
22. DATE SIGNED <i>7-11-67</i>			
23a. BURIAL, CREMATION Burial <input checked="" type="checkbox"/>		23b. DATE THEREOF <i>7/15/1967</i>	
23c. NAME OF CEMETERY OR CREMATORIUM <i>St. Joseph's Cemetery</i>		23d. LOCATION (City or Town) <i>Pomfret, Md.</i>	
24. FUNERAL DIRECTOR <i>Johnson Funeral Home, Pomona, Maryland</i>		ADDRESS	
25a. REC'D BY REGISTRAR <i>JUL 13 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15ME (5) 6M 1 67			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT

09493

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

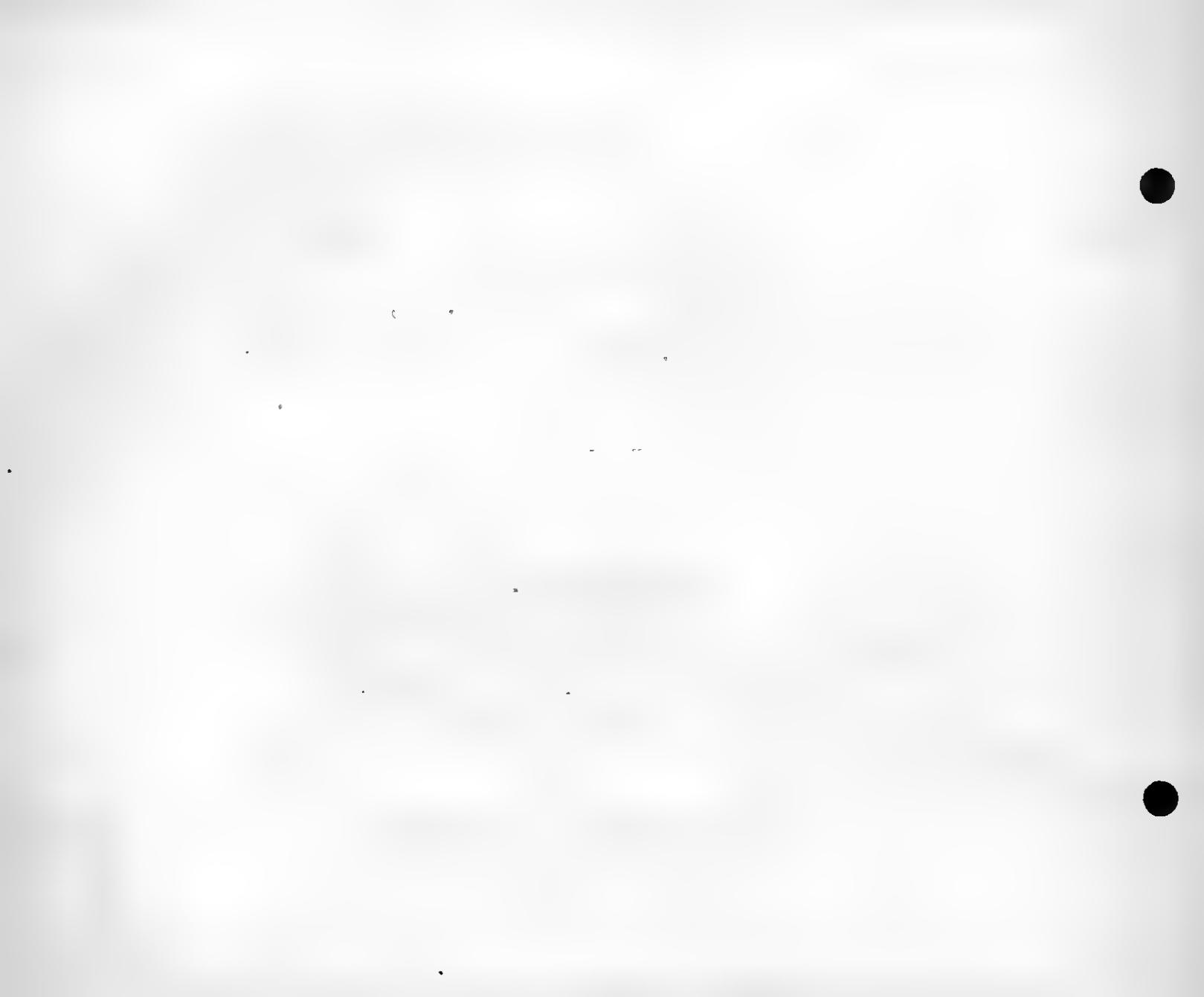
09493

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transcript, and in any event within 72 hours after death.

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY <b>Charles</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b> Waldorf</b>		c LENGTH OF STAY IN lb		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlotte Hall</b>					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS <b>Oaks Road</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) <b>LAVON CLIFTON</b>		First <b>L</b> Middle <b>A</b> Last <b>STANLEY</b>		4 DATE OF DEATH Month <b>July</b> Day <b>21</b> , Year <b>1967</b>					
S SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <b>X</b> NEVER MARRIED <input type="checkbox"/>	W-DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH <b>Aug. 23, 1926</b>	9 AGE (In years last birthday) <b>40</b> yrs	10a USUAL OCCUPATION (Give kind of work done during month working, if ever employed) <b>Mechanic - Heavy Equip. Operator-Construction</b>	10b KIND OF BUSINESS OR INDUSTRY <b>Kentucky</b>	10c BIRTHPLACE (State or foreign country) <b>Kentucky</b>	12 CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13 FATHER'S NAME <b>Vergle Stanley</b>		14 MOTHER'S MAIDEN NAME <b>Effie F. (Unknown)</b>		15 IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		16 IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>			
15 IS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes give war or dates of service <b>Yes</b>		16. SOCIAL SECURITY NO <b>230-20-4329</b>		17 INFORMANT <b>Mrs. Teresa ... Stanley - Charlotte Hall</b>		Address			
18 CAUSE OF DEATH (Enter on one cause per line for Part I, (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>7/23</b> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost <b>Caused between front end</b>		DUE TO (b) DUE TO (c)		Crushed Chest & Suspension Caught between front end Lorry and Garage transm Causing clav. ne		INTERVAL BETWEEN ONSET AND DEATH <b>7-21-67</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Causing clav. ne</b>									
20a EXTERNAL CAUSE WAS PR.MARYLOR CONTR.BJNG <input type="checkbox"/> CAUSE OF DEATH <b>20c TIME OF INJURY Month Day Year July 21 1967</b>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 8) <b>20d INJURY OCCURRED When <input type="checkbox"/> Not at work <input type="checkbox"/> at work <input type="checkbox"/></b>		20e PLACE OF INJURY (Home, farm, factory, street off ce bldg, etc) <b>20f (City or town) Laurel, Maryland</b>		20g (County) <b>Maryland</b>		(State) <b>Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accidental <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <b>J. Edelen</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>7-21-67</b>			
EXAMINER'S NAME (Type) <b>E. J. Edelen, M.D.</b>		23a BURIAL CREMATION, REMOVAL(Specify) <b>Burial</b>		23b DATE THEREOF <b>7/26/1967</b>		23c NAME OF CEMETERY OR CREMATORIAL <b>St. Joseph's Cemetery</b>		23d LOCATION (City or Town, State) <b>La Plata, Maryland</b>	
24 FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc. - La Plata, Md.</b>		ADDRESS		25a REC'D BY REGISTRAR <b>Charles Judge</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
VR A15ME 5 6M 1/67		DATE JUL 25 1967							



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03484

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Charles</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b>		c. LENGTH OF STAY IN MD <b>26</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>34-Cypress Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Zada Armatha Talbott</b>		First	Middle	Lost	4. DATE OF DEATH <b>7-7-67</b>	Month	Day	Year <b>19</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W-US</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-26-1913</b>	9. AGE (In years lost birthday) <b>53</b> yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William E. Giffen</b>		14. MOTHER'S MAIDEN NAME <b>Sylvia Byrne</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>213-40-7813</b>		17. INFORMANT <b>Husband-Sherman Talbott</b>		Address <b>34-Cypress Place</b> <b>Indian Head Md</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Coronary Occlusion-Massive</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerosis General</b> Indefinite (c) <b>Obesity</b> Indefinite								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>7-6-67</b> , 19, to <b>7-7-67</b> , 19, that I last saw the deceased alive on <b>7-7-67</b> , 19, and that death occurred at <b>10-AMM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>7-7-67</b>								
ACTUAL SIGNATURE  M.D. Indian Head Md.								
PHYSICIAN'S NAME (Type) <b>James E. Andrews</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-11-67</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Samples Manor Cem.</b>		22d. LOCATION (City, town, or county) <b>DARGEN, MD.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>HUNT FUNERAL HOME, WALDORF, MD.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>JUL 12 1967</b>		24b. REGISTRAR'S SIGNATURE <b>Judge</b>		
VS A15 (4) 15M 9/55								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

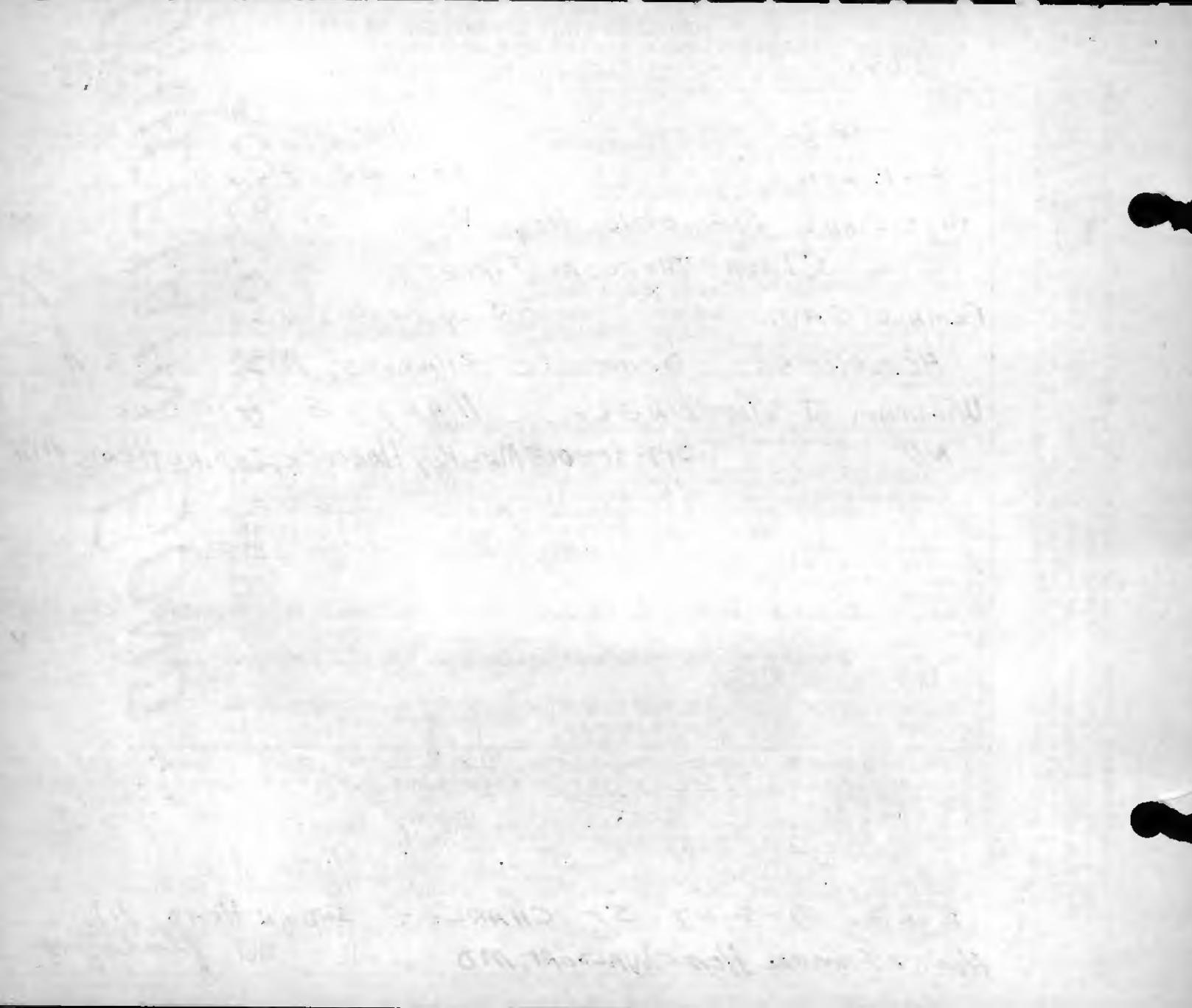
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09495

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)	
CHARLES MARYLAND		a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
LAPLATA		INDIAN HEAD 011	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			
Physicians MEMORIAL Hosp RT 1 Box 42			
3. NAME OF DECEASED (Type or print)	First CLARA	Middle THERESA	Last TIPPETT
4. DATE OF DEATH	JULY 2, 1967	Month	Day Year
5. SEX FEMALE	6. COLOR OR RACE CAU.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 24, 1903 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
HOUSEWORK		Domestic	
11. BIRTHPLACE (County & State, or foreign country) CHARLES MD.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William J. MATTINGLY MARY E. HIGDON Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT			
(Yes, no, or unknown) (If yes give war or dates of service) NC 217-30-0068 MRS. ROY HANCOCK, INDIAN HEAD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> INTERVAL BETWEEN ONSET AND DEATH 4301 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Anteriorolateral Heart Disease</i> 1m. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19 at work <input type="checkbox"/>		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/2/67 to 7/2/67, that (I) (we) last saw the deceased alive on 7/1/67, and that death occurred at 7/2/67 M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Arthur M. Monteiro</i>		22b. DATE SIGNED 7/3/67	
22c. PHYSICIAN'S NAME (Type) ARTHUR M. MONTEIRO		22d. ADDRESS 7A Plaza, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-5-67	
23c. NAME OF CEMETERY OR CREMATORIUM ST CHARLES		23d. LOCATION (City, town or county) (State) INDIAN HEAD MD	
24. FUNERAL DIRECTOR HUNT FUNERAL HOME, WALDORF, MD.		ADDRESS	
		25a. REC'D BY REGISTRAR Charles Judge	
		25b. REGISTRAR'S SIGNATURE	
		DATE JUL 6 1967	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

CERTIFICATE OF DEATH												
09496						09496						
1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSIE</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSIE</b> d. STREET ADDRESS						
3. NAME OF DECEASED (Type or print) <b>Daniel T. Veihmeyer</b>						First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-19-1906</b>	9. AGE (In years last birthday) <b>81 yrs.</b>	10. IF UNDER 1 YEAR <input type="checkbox"/> Months	11. IF UNDER 24 HRS. <input type="checkbox"/> Days	12. IF UNDER 1 YEAR <input type="checkbox"/> Hours	13. IF UNDER 24 HRS. <input type="checkbox"/> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>REAL ESTATE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASH., D.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>DANIEL T. VEIHMEYER</b>						14. MOTHER'S MAIDEN NAME <b>MARY G. FOX</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> <b>WWII</b>						16. SOCIAL SECURITY NO. <b>577-14-0048</b>		17. INFORMANT <b>EVELYN LEINS, 2141 I ST. N. W., WASH., D.C. 20037</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Myocardial Infarction</b> <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> Years DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)				
21. I certify that (I) ( <b>this hospital</b> ) attended the deceased from <b>10 Jul 1962</b> to <b>11 Jul 1962</b> , that (I) ( <b>me</b> ) last saw the deceased alive on <b>12 May 1967</b> , and that death occurred at <b>UNKNM</b> , from causes and on the date stated above.												
22a. SIGNATURE <i>J. Barry Mason</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12 Jul 67</b>								
22c. PHYSICIAN'S NAME (Type) <b>J. G. BARRY MASON</b>		22d. ADDRESS <b>LA PLATA, MD.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7-14-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>CHRIST CH. CEM.</b>		23d. LOCATION (City or Town) <b>WAYSIDE, CHARLES, MD.</b> (County) (State)							
24. FUNERAL DIRECTOR <b>HUNTT FUNERAL HOME, WALDORF, MD.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JUL 17 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Juge</i>						
DATE JUL 17 1967												

132,043

11. 11. 1962

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